| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265717 | A. Building<br>B. Wing | 02/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Grand Manor Health Care Center | 3645 Cook Ave<br>Saint Louis, MO 63113 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30869<br><br>Based on interview and record review, the facility failed to ensure one resident's (Resident #6) right to be free from abuse was not violated, when the resident was abused by another resident (Resident #7), of eight sampled residents. Upon discovery of the abuse, a mental health aide walked away, while the victim was still on the floor with the perpetrator at his/her side, to call for a nurse. During this brief period of time, Resident #7 threw an unlit cigarette at Resident #6. The census was 87.<br><br>Review of the facility's Abuse and Neglect policy, dated 7/2022, showed:<br><br>-Abuse definition: The willful infliction of injury, unreasonable confinement, intimidation, exploitation, mistreatment, or punishment with resulting physical harm, pain, or mental anguish. Included is verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled with technology. Willful, as used in this definition of abuse, means the individual acted deliberately, not that the individual must have intended to inflict injury or harm.<br><br>-Procedure-To ensure no abuse is allowed in the Facility, the following steps will be as follows:<br><br>-Prevention: All residents upon admission are informed of the grievance procedure and the Social Services (SS) Employee introduces him/herself as the person to report concerns. All staff receive education on the definition of abuse and what to do if they should suspect or observe any treatment of a resident that would be deemed abuse. The resident is provided information on how to proceed with filling out a grievance form and who the Grievance Officer on duty is.<br><br>-Protection: If a resident alleges another resident has caused the harm, the residents are to be separated; preferably, to another area of the facility.<br><br>-Instructions when determining alleged abuse: Any staff that observes a resident harming, or attempting to harm, another resident, or staff, threatens self-harm, inappropriate sexual behaviors or elopement attempts must immediately stay with the patient. Staff must inform the charge nurse on the floor, the Administrator, Director of Nursing (DON), and Social Services. The responsible party, with the residents' permission, will be notified. The attending physician/psychiatrist will be notified, and any orders will be documented and followed.<br><br>Review of the facility's undated Smoking policy showed:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Procedure- It is the responsibility of the charge nurse to assign a staff member to supervise resident smoking at designated times, if it has been determined that a resident poses a risk to smoking unsupervised i.e., burning clothing, skin, etc. Cigarettes will be kept secured at the nurses' station. This will be determined by the smoking assessment;<br><br>-At designated times, supervised smoking will occur;<br><br>-Smoking hours are: 9:00 A.M., 11:00 A.M , 2:00 P.M., 4:00 P.M., 8:00 P.M., and 9:00 P.M.;<br><br>-Unsupervised cigarette/cigar smoking in the courtyard is determined by the smoking assessment;<br><br>-Unsupervised smoking is allowed in the courtyard if you have been deemed capable of smoking without supervision. Smoking hours are from 9:00 A.M. to 9:00 P.M.;<br><br>-It is prohibited for the resident to smoke cigarettes/cigars in any other area of the building unless weather changes occur (i.e., temps <32 or above 90 degrees);<br><br>-Smoking violations will be handled by the Social Services department, Director of Nursing and the Administrator which may include but not limited to a 30-day discharge/Immediate discharge notice for continued noncompliance with this policy;<br><br>Review of Resident #6's care plan showed:<br><br>-Focus: Start Date: 8/15/2023 for Activities. Resident attends limited groups because he/she prefers to spend time with his/her mate, who also lives in the facility. Goal: Resident will maintain his/her current activity level through the next review. Interventions: Continue to invite to all activities;<br><br>-Focus: Start Date: 9/30/2021 for smoking cigarettes at the facility. Goal: Resident will not have any issues related to smoking while in the facility. Interventions: Resident requires actual supervision with smoking.<br><br>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/17/23, showed:<br><br>-Intact cognition;<br><br>-No behaviors;<br><br>-Diagnoses included end stage renal disease (ESRD, permanent kidney failure leading to long-term dialysis to maintain life), heart failure, diabetes, and schizophrenia (a serious mental disorder).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #6's progress note, dated 1/23/24 at 7:00 A.M., showed the charge nurse was called to the downstairs dining room because Resident #6 was found on the floor. Resident #6 was found sitting on the floor, with two staff members at his/her side. The charge nurse was told there had been a resident-to-resident altercation. The resident said Resident #7 pushed him/her down, his/her head did not hit anything, and he/she was not hurt. A body assessment revealed no visible injury, physical assessment revealed no trauma to the head, neurological checks were within normal limits, range of motion was normal for all extremities, vital signs were within normal range, and the resident denied pain. The two residents live on different floors. The resident was educated on not being on the same floor together and to have supervised only smoke breaks. The psychiatric physician was notified and said the resident was to have no contact with the other resident, under any circumstances. The resident's physician/nurse practitioner and the police were called.<br><br>Review of Resident #6's progress note, written by the DON, dated 1/23/24 at 8:10 A.M., showed both Resident #6 and Resident #7 said Resident #7 was upset because on 1/22/24, Resident #6 had his/her door locked and said it was because he/she was hiding from another resident, who was also interested in him/her, but he/she was not. Resident #6 had also shared Resident #7's food with this other resident. The outside food had been delivered to the facility by Resident #7's family member, handed to Resident #6, and was not to be shared with anyone. Resident #6 would not give up the name of the other resident and that angered Resident #7. They were over that, until this morning when Resident #6 had his/her door locked which sparked Resident #7's accusation that Resident #6 had another boy/girlfriend. Resident #7 grabbed Resident #6's shirt, pushed him/her to the floor, threw a cigarette butt toward him/her, and tapped his/her face three times. Resident #6 said it was like a firm tap, not a hard slap. The police came and said no charges would be filed against either resident, at that time. Family, physician, and Department of Health and Senior Services (DHSS) were notified.<br><br>Review of Resident #7's annual MDS, dated [DATE], showed:<br><br>-Intact cognition;<br><br>-No behaviors;<br><br>-Independent with activities of daily living (ADL);<br><br>-Diagnoses included diabetes.<br><br>Review of Resident #7's care plan showed:<br><br>-Focus: Start Date: 11/09/23 for behavioral symptoms related to history of polysubstance abuse. Goal: Resident will not use illegal substances while at the facility. Interventions: Closely monitor the resident for signs and symptoms of substance abuse and report to the physician immediately.<br><br>Review of Resident #7's progress note, dated 1/23/23 at 7:00 A.M., showed the Mental Health Aide reported the resident had pushed Resident #6 down and threw a cigarette at him/her. The residents were separated. Resident #7 had no injuries and was restricted to the floor. The resident's physician was notified and received order for a psychiatric evaluation. Awaiting a return call from the resident's psychiatrist.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #7's progress note, by the DON, dated 1/23/23 at 8:15 A.M., showed the resident said he/she was upset because Resident #6 had his/her door locked and would not tell him/her the name of the resident he/she was hiding from. Resident #6 also gave away, to another resident, some of the food his/her sibling had brought for him/her to share with Resident #6. The police came but did not take the resident to jail, because it was one resident's word against the other resident's word, and there were no witnesses to the hitting. The DON informed the police that staff did see Resident #7 flick his/her cigarette at Resident #6. The police said they would write it in their report, but no charges would be filed at this time. The resident's family and DHSS was notified. The Administrator and Social Worker were notified, and an immediate discharge letter was given to the resident. Resident #7 said he/she was done with his/her boy/girlfriend and wanted to discharge to another facility at this time.<br><br>Review of Resident #7's progress note, dated 1/23/23 at 12:50 P.M., showed the charge nurse spoke with the psychiatric nurse practitioner, regarding the resident-to-resident altercation, and received orders to send the resident out for a psychiatric evaluation. A message was left on the family's answering machine.<br><br>Review of Resident #7's progress note, dated 1/23/24 at 2:21 P.M., showed the resident was transported to the hospital, via the facility's contract ambulance service, and a copy of his/her against medical advice discharge and immediate discharge papers was given to the resident.<br><br>Review of the DON's investigation summary, dated 1/23/24, showed on the morning of 1/23/24, around 7:00 A.M., Resident #6 said Resident #7 was upset because he/she had locked his/her door the night before, to avoid being contacted by another resident. Resident #6 shared some chicken with another resident, on 1/22/24, so the other resident thought Resident #6 liked him/her. Resident #6 refused to tell Resident #7 the name of the other resident, because he/she did not want Resident #7 to become upset and approach the other resident. Resident #7 became upset anyway, because he/she refused to give him/her the name of the other resident. Resident #7 then threw an ashtray toward Resident #6, but it did not hit him/her, then Resident #7 firmly tapped him/her on the face three times. Resident #6 stood up, to get away, and he/she grabbed his/her shirt and pushed, which caused him/her to fall on his/her buttocks. Resident #6 yelled for help and a dietary aide entered the dining room. Resident #7 called out Resident #6's name and flicked a cigarette butt toward him/her, which was witnessed by staff. Resident #7 agreed he/she became upset and grabbed Resident # 6's shirt and pushed him/her to the floor. The two were immediately separated and the nurse was notified. Resident #6 was assessed for injuries, and none were noted at that time. Both residents lived on different floors and were placed on supervised monitoring to avoid any further contact with each other. The police were notified but the officer refused to file any charges or take Resident #7 to jail. The officer said Resident #7 denied hitting Resident #6 and there was no visible redness or bruising noted to Resident #6. It was one person's word against the other person's word, as there were no witnesses to the abuse. The DON told the officer Resident #7 admitted to grabbing Resident # 6's shirt, causing Resident #6 to fall. The officer said the facility needed to handle it. Resident #7 was issued an immediate discharge, with information pertaining to his/her right to appeal. Resident #7 said he/she was leaving on his/her own, against medical advice, was not going to return, and was not going to the hospital. The ambulance attendants were already at the facility, spoke to the resident, who agreed to be taken to the hospital if his/her electric wheelchair could accompany him/her. The attendants said the wheelchair could not be taken, so the facility transported the resident's wheelchair to the hospital.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/26/24 at 3:21 P.M., Resident #6 said it all started on 1/23/24 when Resident #7 came to his/her room, between 6:15 A.M. and 6:30 A.M., and his/her door was locked. Resident #7 wanted to know why it was locked. He/She said it was because someone was after him/her. Resident #6 refused to give the other resident's name to Resident #7, because he/she did not want Resident #7 to get kicked out of the facility. They left to go to the downstairs dining room to smoke because it was too cold to go outside. Resident #7 beat him/her to the dining room and was hiding in the dark. Resident #7 came out of the darkness, when he/she entered the dining room, and started at him/her again. Resident #7 continued to ask questions about who was after him/her and Resident #6 continued to say he/she was not going to say because he/she did not want Resident #7 to get into a fight and get kicked out. Resident #7 kept asking and he/she started ignoring him/her. Resident #6 sat down to finish the cigarette and Resident #7 picked up an ash tray, threw it across the room and said, Do you think this is a fucking game? There was no one else in the dining room at that time. Resident #6 got up to put the cigarette out in the ash tray on another table. Resident #7 grabbed the front of his/her shirt, pushed him/her to the floor, then wheeled him/herself out of the dining room to see if anyone had heard. Resident #7 returned and told him/her to get off the floor. Resident #6 said he/she was laying on the floor because his/her legs were not strong enough to get up. Resident #7 came over and tried to roll over him/her with his/her wheelchair. He/She ran the wheelchair up to his/her waist, but the wheelchair wheels would not go any further. It did not hurt because he/she was wearing a coat. Resident #6 kept struggling and managed to pull him/herself up and onto one of the dining room chairs. Resident #7 came over and, with both hands, pushed him/her off the chair and onto the floor. It did not hurt because the chair broke the fall by hitting the floor first. Resident #7 kept telling him/her to get up, while he/she was sitting on the floor, then Resident #7 smacked me twice in the face, on my left cheek. Resident #6 said it did not hurt, because he/she actually did it soft so it would leave no mark. Resident #7 then started holding his/her face. Resident #6 heard staff at the time clock and hollered for help. A cafeteria employee and another staff person came in and asked how he/she got on the floor. He/She told them Resident #7 had pushed him/her. They asked Resident #7 why, but he/she turned around and left the dining room. They took Resident #6 upstairs and there were no injuries. When asked if Resident #7 was upset about his/her food, which was delivered by a family member the day before, Resident #6 said he/she was downstairs in the lobby when Resident #7's sibling came in with some chicken, around 3:00 P.M. or 4:00 P.M. the day before, gave it to him/her, and said, this is for you. He/She was tired of chicken and put it back in the bag. A resident sitting beside him/her asked if he/she could have some of it. Resident #6 said he/she did not know it was for Resident #7, because Resident #7's sibling said it was for him/her. They went upstairs to the resident's room, and he/she gave the other resident some of the chicken and fries. Resident #7 showed up and asked where his/her food was. Resident #6 said, What food? Resident #7 said the food his/her sibling delivered to the facility for him/her. Resident #6 said he/she gave it to another resident, because he/she did not know it was for Resident #7. Resident #7 said, You thought my sibling came all the way from the city to bring you something to eat? Resident #6 gave him/her the bag of food. Resident #7 got mad, said there were only 3 wings and 3 fries left, and stormed out. Resident #7 returned and asked what all his/her sibling had brought him/her. Resident #6 told him/her there was a second bag with cigarettes and popcorn in it. He/She gave Resident #7 the second bag. Resident #7 looked inside the bag and saw only one bag of popcorn, that had been opened, and no cigarettes. He/She asked where the cigarettes were. Resident #6 said the cigarettes were in his/her drawer. Resident #7 asked why his/her cigarettes were opened and Resident #6 said because he/she had smoked one. Resident #7 asked why, and Resident #6 said because Resident #7's sibling said, I could have it. Resident #7 got mad and rolled out of the room, but returned all evening long, saying he/she had hustled up the money to get it and could not believe he/she took it and gave his/her food away. Resident #6 said no one was after him/her and he/she felt safe, as long as Resident #7 was no longer there.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/26/24 at 3:00 P.M., Mental Health Aide (MHA) A said he/she clocked in at 6:45 A.M. on 1/23/24 and went to the dining room to get a beverage from the vending machine. Upon entering the dining room, Resident #6 was sitting on the floor and Resident #7 was in his/her wheelchair, about 10 to 15 feet away from Resident #6. Resident #6 was saying, help, (he/she) pushed me down. Resident #7 said, Fuck that bitch and stormed out of the dining room.<br><br>Review of MHA A's written statement, dated 1/23/24, showed at 6:50 A.M., when he/she walked into the dining room, Resident #6 was on the floor and said, help, (he/she) pushed me down. MHA A went to the front desk and asked the receptionist to call the second-floor nurse to come and assess the resident on the floor. MHA A went back into the dining room and asked Resident #7 why he/she did that, and Resident #7 said, Fuck that bitch. MHA A called the DON.<br><br>During an interview on 1/26/24 at 3:10 P.M., Dietary Aide (DA) B said he/she clocked in at 6:50 A.M. and before reaching the dining room, he/she heard Resident #7 call Resident #6 a bitch. MHA A was walking out of the dining room, to ask the receptionist in the lobby to call a nurse to the dining room, as DA B was walking into the dining room. Resident #7 was beside Resident #6, who was sitting on the floor. Resident #7 threw his/her whole, unlit, cigarette at Resident #6, hitting his/her upper torso or shoulder area. DA B told Resident #7 to stop it. Resident #6 said Resident #7 had pushed him/her to the floor. Resident #6 was not crying and did not appear to be in pain. Resident #7 said he/she did not try to push him/her down and rolled out of the dining room when the nurses showed up.<br><br>Review of DA B's written statement, dated 1/23/24 (no time), showed as he/she walked into the dining room, Resident #7 threw a cigarette at Resident #6. Resident # 6 was on the floor and said Resident #7 pushed him/her out of the chair and slapped him/her around.<br><br>Review of Licensed Practical Nurse (LPN) C's statement, dated 1/23/24, showed he/she was called to the dining room for a resident found on the floor. Upon arrival to the dining room, Resident #6 was on the floor and said Resident #7 had pushed him/her to the floor twice, slapped him/her, and tried to run him/her over with the wheelchair. Assessment of Resident #6's body showed no signs of injury. LPN C was also told Resident #7 flicked a cigarette onto Resident #6, which was witnessed by staff.<br><br>During an interview on 1/26/24 at 11:00 A.M., the DON said Resident #7 pushed Resident #6 down. Resident #6 said Resident #7 pushed him/her and described the facial contact as a firm three taps to his/her face. Resident #7 said Resident #6 fell backwards as he/she grabbed him/her. Resident #6's face was not red, and the police asked why it was not red, if he/she was slapped. The police said Resident #7 said he/she grabbed Resident #6's shirt and he/she fell backwards because he/she pulled away. DA B saw Resident #7 flick a cigarette butt at Resident #6. Resident #7 said he/she was upset because Resident #6 shared the chicken, that was given to him/her by his/her sibling, with another resident. At 3:59 P.M., the DON said Resident #6 did not go into that much detail, regarding all that took place in the dining room. Resident #6 never said, to her or the police, that Resident #7 pushed him/her down twice. The DON said she kept telling Resident #6, if Resident #7 slapped him/her, that was assault. Resident #7 pushed Resident #6 down, and that was assault. Resident #6 was mad and wanted the police to take Resident #7 to jail, however the police changed their demeanor after they saw Resident #7 was in a wheelchair.<br><br>MO00230706 |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30869<br><br>Based on interview and record review, the facility failed to provide a medication to one of eight sampled residents (Resident #1) whose diagnosis included human immunodeficiency virus (HIV, a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases) and progressive multifocal leukoencephalopathy (PML, a disease of the white matter of the brain, caused by a virus infection (polyomavirus JC) that targets cells that make the myelin sheath-the material that insulates nerve cells) when the resident was admitted to the facility on [DATE] and was not given their Biktarvy (contains three antiviral medications). The resident was discharged to the hospital on [DATE] when he/she was unable to respond. The resident expired at the hospital. The census was 87.<br><br>The administrator was notified on [DATE] at 5:56 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification.<br><br>Review of the facility's undated Following Physician Orders policy showed:<br><br>-Procedure:<br><br>-When a medication order is received the Charge Nurse receiving the order will write the order on the right-side of the Physician Order Sheet (POS);<br><br>-In addition, a telephone order sheet will be completed. The yellow copy is taped in the chart, the white copy goes to medical records, and the pink copy goes to the Director of Nursing (DON). If this is a routine order the Nurse will write the order in the box on the left side of the Physician Orders Sheet (POS) as well;<br><br>-A nurse's note is written when an order is received, as to why the order was obtained and that the order was carried out;<br><br>-The Nurse will fax the top copy of the POS, or write on a new Order form, to the pharmacy to be filled;<br><br>-The Nurse will write the order on the Medication Administrator Record (MAR), with the date the order is received;<br><br>-The time of administration is recorded on the POS and the MAR (observing dosing intervals as appropriate to the medication);<br><br>-The Nurse will monitor the pharmacy deliveries to ensure that the medication is received. If the pharmacy has not delivered the medication before the end of that nurse's shift, the nurse will communicate to the next shift to monitor for the medication;<br><br>-If the medication is not received on the same day that it is faxed, the Nurse will call the pharmacy to ascertain the reason for delay;<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -The nurse will notify the Physician of the delay;<br><br>-The nurse will document the delay and the reason for the delay in the nurse's notes;<br><br>-When the medication is received the Nurse will ensure that it is administered in a timely fashion as ordered;<br><br>-The Nurse will ensure that after the medication is administered, the MAR is initialed properly, according to the five rights and three checks to ensure the correct medication was given;<br><br>-Stock medications that are available from the facility emergency kit (E-kit) will be used to start the resident on their regimen;<br><br>-Any physician order that the facility cannot obtain and carry out in a timely manner, the Charge Nurse will inform the ordering doctor and make the appropriate documentation in the resident chart;<br><br>-Should it be determined that a medication error has occurred either by omission, an incorrect medication administration, wrong time, wrong dosage, or wrong patient, the Physician is to be notified immediately and informed.<br><br>Review of Resident #1's paper chart, from the resident's prior Missouri facility, showed<br><br>-Rehabilitation Hospital discharge and clinical summary information, dated [DATE], showed the resident was treated at the medical hospital for PML, which has a very severe and high mortality risk, and the treatment was to continue the daily Biktarvy medication. Instructions were given for the resident to follow-up with the Infectious Disease (ID) Case Manager at the hospital, to set up appointments. The resident was to follow up for ID, neuro-immunology, general neurology, cardiology, and nephrology. The resident's discharge medication list included Biktarvy, dapsone, metoprolol (treats high blood pressure), Miralax (treats constipation), ibuprofen, and acetaminophen;<br><br>-Facility's written admission orders, dated [DATE], showed Biktarvy [DATE] milligrams (mg), one tablet daily, for HIV and dapsone 100 mg daily for HIV.<br><br>Review of the facility's contract pharmacy's medication delivery sheet, dated [DATE], showed 30 tablets of Biktarvy were delivered to the resident's former Missouri facility, which closed on [DATE].<br><br>Review of the resident's referral email, dated [DATE] at 11:05 A.M., from the company's Illinois facility Administrator, and sent to the facility's Admissions Coordinator (AC) D, with three electronic medical record attachments, showed:<br><br>-Physician order report, dated [DATE], start date of [DATE], with a list of 26 physician orders that included the following medication order:<br><br>-Biktarvy tablet, [DATE] mg, one tablet at 8:00 A.M.;<br><br>-Face Sheet (a document which gives a resident's personal demographics, emergency contact details, and medical diagnoses). There was no diagnosis of PML on the face sheet.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265717 | A. Building<br>B. Wing | 02/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Grand Manor Health Care Center | 3645 Cook Ave<br>Saint Louis, MO 63113 |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -[DATE] at 10:41 A.M., Social Services documented the resident's referral packet was emailed to their Missouri facility, per family's request to be closer to home.<br><br>During an interview on [DATE] at 12:20 P.M., the Illinois facility's Director of Nursing (DON) (from the resident's previous facility) said they sent the resident's discharge paperwork with the resident, when they transported him/her to the Missouri facility ([DATE]).<br><br>Review of an email, dated [DATE] at 12:30 P.M., sent from the Illinois facility Administrator to the surveyor, was a copy of the IL facility's Discharge Plan, Instructions, and Recap of Stay (the resident's IL facility discharge summary), dated [DATE], and a copy of the resident's POS, dated [DATE]. The IL Administrator said this discharge summary and POS were sent with the resident on [DATE], to his/her new facility. The discharge summary showed:<br><br>-Initial admission to Illinois facility was [DATE];<br><br>-discharge date [DATE] to the Missouri facility;<br><br>-Contact Illinois facility social services designee, telephone number written in, for any questions;<br><br>-Comments: Biktarvy [DATE] mg daily;<br><br>-Non-ambulatory and assistance needed with activities of daily living (ADLs);<br><br>-Alert, oriented, comprehends questions and commands and has accurate recall;<br><br>-Copy of electronic Physician Order Sheets, dated [DATE], included the following medication orders:<br><br>-Biktarvy tablet, [DATE] milligram (mg), one tablet at 8:00 A.M.<br><br>During an interview on [DATE] at 3:00 P.M., AC D said the Illinois facility emailed the resident's electronic referral, with the medical attachments, but he/she did not have a copy of the email. Once he/she uploads the resident's International Classification of Diseases codes (ICD-9 codes, diagnosis coding system) into the resident's electronic medical record and forwards the medical record attachments, which include the Face Sheet, history and physical (H&P, a record of the physical exam, brief historical information, and medical diagnoses), and physician's orders, to the facility's Medical Records employee, to upload into the resident's electronic medical record, the email is deleted. AC D said he/she received a copy of the resident's H&P and went through it. AC D said he/she did not upload or add any of the referral information into the resident's electronic medical record, because he/she was locked out of the electronic medical record at that time. AC D said he/she forwarded the referral packet to this facility's Medical Records employee for uploading into the resident's electronic medical record.<br><br>During an interview on [DATE] at 3:20 P.M., Medical Records (MR) E said he/she never received the resident's referral packet.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the resident's electronic progress note, dated [DATE] at 1:29 P.M., showed the DON documented the resident was transferred from their sister facility with belongings. The resident denied pain or discomfort during transfer. The resident was up in the wheelchair, propelling self on and off the unit. The oncoming nurse was made aware of the new resident and vital signs were obtained.<br><br>Review of the resident's paper nurse's notes, dated [DATE] (no time), showed Licensed Practical Nurse (LPN) F documented the resident was a new admission, alert and oriented two to three, with some confusion at times. Family aware of resident's transfer with medications and belongings. Resident was pleasant, quiet, and propelled self in wheelchair on the unit. Vital signs were within normal limits and oxygen saturation was 100% on room air. Awaiting return call from the resident's physician.<br><br>Review of the resident's care plan showed:<br><br>Problem Start Date: [DATE] for diagnosis of HIV. Goal: Resident will remain free of infection and maintain skin integrity while preventing transmission through next review date. Interventions: Administer HIV medications as ordered. Coordinate with Center for Infectious Disease to ensure agreement of plan of care. Monitor for side effects of medication. The most common side effects include nausea, vomiting, diarrhea, fever, loss of appetite, hair loss, cough, headache, stomach pains, tiredness, runny nose, insomnia (difficulty sleeping), joint pain, rash, dizziness, muscle pain, and hypersensitivity reaction. Liver toxicity is common to all treatment regimens and should be monitored by regular blood work including liver enzymes. Observe for signs and symptoms of high fever, dehydration, or malnutrition, unstable or changing vital signs, concerns over failure to take medications prescribed, increasing depression and report to MD. Provide information about the disease process and support psychosocial adjustment;<br><br>-The care plan showed no problems, goals, or interventions related to the resident's diagnosis of PML or of complications related to not receiving his/her Biktarvy medication<br><br>Review of the facility's paper Medication Administrator Record (MAR), dated [DATE], showed:<br><br>-No order for Biktarvy [DATE]mg through [DATE];<br><br>-Biktarvy [DATE] mg, start date of [DATE], with documentation the medication was not given on [DATE] because it was not available, and the nurse was aware.<br><br>--Documentation for [DATE] through [DATE], showed the Biktarvy was not available, without documentation the nurse or physician was made aware.<br><br>Review of the resident's paper nurse's note, dated [DATE] 3:00 P.M. to 11:00 P.M., showed LPN F documented a call was placed to the pharmacy related to the resident's medications and Pharmacy Technician (PT) G said the resident's medications would be out on the next run.<br><br>Review of the resident's paper nurse's note, dated [DATE], (no time), showed LPN F documented:<br><br>-The resident's medications arrived, but there was no Biktarvy. LPN F called the pharmacy and spoke with pharmacist (RPh) H, who said it was too soon to refill the medication because a 30-day supply of the resident's Biktarvy was sent out on [DATE] (to previous facility).<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -There was no documentation of physician notification reporting the medication was unavailable and was not going to be given as ordered;<br><br>-There was no documentation the DON or Administrator was notified;<br><br>-There was no documentation of family notification;<br><br>-There were no further paper nurse's notes documented until [DATE].<br><br>Review of the resident's paper nurse's note, dated [DATE] (no time), showed Registered Nurse (RN) I documented:<br><br>-They were still unable to locate the resident's paper chart. Resident still not in the system. The resident's physician was notified the resident's medication (no name of medication documented) was unavailable, and pharmacy said a medication refill was too soon. Resident was up in the wheelchair, alert to self, no signs or symptoms of pain or discomfort, afebrile (free from fever), temperature (T) 97.9 degrees Fahrenheit (normal range, 97 degrees to 99 degrees Fahrenheit), pulse (HR) 76 (normal range is 60 to 100 beats per minute), and blood pressure (BP) was 130/ (diastolic reading was illegible). Normal range, systolic ,d+[DATE] and diastolic ,d+[DATE]).<br><br>-There was no documentation of the physician's response to no available Biktarvy;<br><br>-There was no documentation the DON or Administrator was notified there was no Biktarvy<br><br>During an interview on [DATE] at 10:10 A.M., PT G said they had no clear record of the resident being at the facility until [DATE]. The Biktarvy order was sent to them on [DATE] and they tried to fill it, but it was over the facility's approved amount.<br><br>During an interview on [DATE] at 1:38 P.M., the Illinois facility's Administrator said their Accounts Receivable (AR) Specialist, who is shared by both facilities, said she delivered the resident's original paper chart to the Missouri facility on [DATE].<br><br>During an interview on [DATE] at 2:45 P.M., Missouri Pharmacy Supervisor (PS) O said she investigated the situation and spoke with RPh H. PS O said they had no record of anything from the facility until [DATE], when the resident's orders were received electronically from the facility. Therefore, there could not have been a phone call between the facility nurse, PT G and RPh H, on [DATE]. There were no orders in the system, so there was no order there to talk about. RPh H canceled the resident's Biktarvy order on [DATE] because it was rejected in the system, for the high dollar amount. It won't let the pharmacists process orders that are over the facility limit. RPh sent a fax to the facility on [DATE], regarding the Biktarvy being over the facility amount and requiring approval from the DON or Administrator to be processed. They received no return fax or verbal approval from the facility for the Biktarvy.<br><br>Review of the resident's electronic and paper progress notes, [DATE]-[DATE], showed no documentation regarding the medication being over the facility limit and requiring Administrator or DON approval to send. There was no documentation a fax arrived from the pharmacy, indicating the Biktarvy was over the facility's monetary limit and required DON or Administrator approval to send.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-The resident was unable to complete the cognition interview;<br><br>-Functional self-care abilities:<br><br>-Independent with bed mobility, moving from sitting to lying flat, moving from lying on back to sitting up on side of bed without back support, feeding self, wheeling self in wheelchair for 50 feet and making two turns, wheeling self in wheelchair for 150 feet within a corridor;<br><br>-Staff supervision or touching assistance with oral hygiene and upper body dressing;<br><br>-Partial/moderate staff assistance with bathing self, lower body dressing, personal hygiene, and toilet transfers;<br><br>-Dependent on staff for toileting hygiene;<br><br>-Diagnoses included deep venous thrombosis (DVT, a blood clot in one or more of the deep veins in the body, usually the legs), renal failure (kidney disease), hyperkalemia (a high level of potassium in the blood) and malnutrition.<br><br>Review of the facility's paper MAR, dated [DATE], showed:<br><br>-Biktarvy had nursing staff initials circled, from [DATE] through [DATE], indicating the medication was not given.<br><br>-There was one written note, on the back side of the MAR, dated [DATE], which said the medication was not there and the nurse was notified.<br><br>Review of the resident's electronic progress notes, dated [DATE], showed:<br><br>-2:48 P.M., a call was placed to the resident' physician, to review medications, and awaiting a return call;<br><br>-3:22 P.M., physician called back and received a new order for a consult at the ID clinic.<br><br>During an interview on [DATE] at 2:36 P.M., Certified Nurse Aide (CNA) M said the resident seemed tired and was sleepy on Sunday, [DATE], was not talking much, and would just look at her/him. CNA M said he/she thought he/she was just tired. CNA M said he/she put the resident in a Geri chair (a large, padded chair designed to help seniors with limited mobility) that day because the resident was sliding out of the wheelchair. The resident ate some of his/her lunch and he/she laid the resident down after lunch.<br><br>Review of the resident's electronic progress note, dated [DATE], showed LPN F documented:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -1:17 P.M., the resident appeared to be having a dry cough, was lethargic, fatigued, alert, unable to eat, and unable to respond when spoken to; just looked at staff. Vital signs were 98.9 (T), 18 (respirations), 129 (HR), and ,d+[DATE] (BP). The physician was notified, and order received to send the resident to the hospital. The resident's family was notified;<br><br>-2:39 P.M., ambulance arrived to transport the resident to the hospital.<br><br>During an interview on [DATE] at 1:00 P.M., LPN F said on [DATE] between 10:00 A.M. and 12:00 P.M., the resident had increased weakness, was no longer oriented, and was not talking. The resident had a change in condition. LPN F notified the physician and sent the resident to the hospital.<br><br>During an interview on [DATE] at 1:57 P.M., CNA K said he/she cared for the resident twice. Once shortly after admission and on the day they sent him/her out to the hospital. When he/she first cared for the resident, he/she could stand on one side and pivot, was able to talk, but did not talk a lot, was using a urinal, and helped with rolling in bed. On [DATE], sometime after 10:00 A.M., the resident did not look good, wasn't helping with anything, made no eye contact, and was not responding when spoken to. CNA K told the nurse there was a change in the resident's condition.<br><br>Review of the hospital record, dated [DATE], showed the family spoke with the resident on [DATE] and he/she was at baseline. On [DATE], family went to visit and the resident was unable to speak and was slow to respond in any manner. On [DATE], the resident was unresponsive and brought to the emergency room . The family reported he/she took Biktarvy at the facility, alternate information indicates he/she was not getting Biktarvy. Upon arrival to the Emergency Department, the resident had hypertension (high blood pressure), was tachycardic (heart rate over 100 beats per minute), and elevated blood urea nitrogen (BUN, tests kidney function) 73 (normal range ,d+[DATE]). His/Her diagnoses included altered mental status secondary to progressive PML, HIV, acute kidney injury on chronic kidney disease, hypernatremia (a high concentration of sodium in the blood), concern for neurostorming (paroxysmal sympathetic hyperactivity, a complication of severe brain injury which is characterized by episodes of hypertension, tachycardia, tachypnea, diaphoresis, fever, and dystonic posturing). The resident expired on [DATE].<br><br>During an interview on [DATE] at 2:36 P.M., the resident's ID Physician N, (who treated the resident during his/her hospitalization from [DATE] through [DATE]), said he/she felt very strongly the resident not being on the Biktarvy was a contributing factor in the resident's death. The resident died from complications from the uncontrolled PML infection. The resident needed to be on HIV medication daily, for the rest of his/her life, to maintain the immune system. Without the Biktarvy, his/her immune system was too weak, so the virus was allowed to infect the brain and spread. The resident's only chance of surviving was for him/her to stay on the Biktarvy.<br><br>Review of the DON's typed investigation summary, dated [DATE], showed:<br><br>-On [DATE], the DON called their pharmacy manager, regarding the need for the residents' physicians orders and medication lists, for the many residents who were recently admitted to their facility when their sister facility was evacuated. The pharmacy manager said they were working on this for all the facilities who admitted the evacuees.<br><br>-On [DATE], the resident's original paper chart arrived, and the nurse was able to admit the resident into their electronic system and order his/her medications via the computer.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -On [DATE], the resident's medications arrived from the pharmacy, except for the Biktarvy. LPN F called the pharmacy technician and was told it was too soon to refill and they could not send it out until after [DATE], because a 30-day supply had been sent to their sister facility on [DATE] and the cost was billed to that facility, due to non-coverage by insurance. LPN F asked them to send it to the facility, as they had no idea where the original medication was due to the unforeseen circumstances of the facility's closure. The technician said the cost of the medication exceeded the facility's dollar amount and they would have to ensure payment before the medication could be sent out.<br><br>-On [DATE], the resident's Biktarvy remained unavailable due to non-coverage by insurance and current non-payment issues with the facility.<br><br>-On [DATE], the resident's facility physician was notified and said to call the ID Center to see it that physician could get the medication. The ID clinic was called and said they would need to see the resident first, since the resident had not been seen there since 2020. The facility's transportation department was told to call the clinic back to schedule an appointment and arrange transportation.<br><br>-On [DATE] staff noted the resident had a poor appetite and was not going out to smoke, which he/she looked forward to daily.<br><br>During an interview on [DATE] at 1:00 P.M., LPN F said the facility in Illinois brought the resident to the building. The resident only came with three medication bubble cards in a white trash bag. One was folic acid, and he/she could not recall what the other two were. LPN F said he/she called the Illinois facility three times, to get report from the resident's nurse, but they either left him/her on hold, hung up, or did not answer the phone. LPN F called the resident's facility physician and got admission orders for the bubble cards the resident came with. LPN F told the DON and the Administrator the resident's paper chart did not come with the resident. The Administrator said she was going to call their corporate office. LPN F said he/she did not think to call the pharmacy to ask them what medications the resident was on, because he/she thought the resident was only taking the three medications he/she came with. LPN F said the resident was alert and oriented, but did not ask him/her about his/her medications. LPN F put all the resident's orders in the next day, when his/her chart came. The Biktarvy did not come, so he/she called the pharmacy and was told it was too early to reorder. LPN F said he/she could not do anything about that and could not recall if he/she notified the physician or not. LPN F did not look through the resident's chart, because the resident's diagnoses were on his/her Face Sheet.<br><br>During an interview on [DATE] at 1:55 P.M., LPN F said the resident had lived on an unlocked floor at the facility which closed. LPN F went there to find residents' medications, who admitted to their facility from there, but found none. LPN F spoke with PT G, who knew they had no Biktarvy, but said it was too soon to send more. LPN F said he/she called the physician but did not recall what he said.<br><br>During an interview on [DATE] at 1:40 P.M., LPN J said the CMT did not notify him/her the resident was not getting the Biktarvy. LPN J called the resident's physician to get an order for a consult to the ID clinic. (There was no paper or electronic nurse's note, from LPN J, regarding a call to the resident's physician for an order for an ID consultation.)<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 12:32 P.M., the resident's facility physician said he did not see the resident at the facility, before the resident was discharged to the hospital. The physician was out of town until [DATE], and a nurse called him during that time (date unknown). The nurse said the resident's Biktarvy was unavailable. Biktarvy is a special medication for HIV. He told the nurse to call the ID physician, the one who ordered it, to let them know so they can switch to another medication. The physician said he was not told the resident had PML and the nurses should notify him, the same day any medication is not available to be given.<br><br>During an interview on [DATE] at 11:30 A.M., LPN F said they did not get the resident's paper chart until [DATE], but they had his/her physician order sheets, which were in the resident's electronic medical record. He/She added the Biktarvy to the MAR then, the day the resident was admitted . The resident came to the facility with no Biktarvy.<br><br>Review of an email to the surveyor, dated [DATE] at 1:09 P.M., from RPh L with the facility's Missouri pharmacy, showed they did not receive admission medication orders for the resident until [DATE], and the orders were submitted electronically. Per the facility's rules, they did not send the Biktarvy because it flagged for a high dollar amount. Per the pharmacy's protocol, they faxed the facility a notice to have the Administrator or DON sign the approval form and return it. They did not receive the signed approval form, to send the Biktarvy. Email attachments showed:<br><br>-[DATE], delivery receipt of the Biktarvy to the resident's former Missouri facility;<br><br>-[DATE], electronic physician orders, from the facility, for the resident's Biktarvy;<br><br>-[DATE] at 10:25 P.M., fax confirmation of the notice sent to the facility which said the Biktarvy medication exceeded the facility's maximum dollar amount and authorization from the DON/Administrator was required, prior to dispensing the medication;<br><br>-[DATE], delivery receipt for the resident's other medications. The Biktarvy was not delivered.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 12:30 P.M., the DON said their resident's medical charts were not completely electronic, as they continued to use paper charts. All MARs and Treatment Administration Records (TARs) were paper. Neither the resident's discharge packet, nor the resident's paper chart came with the resident on [DATE], when he/she was transferred from the Illinois facility back to Missouri. The Illinois facility did not tell them about the resident's Biktarvy medication, and he/she came with none. If she knew the resident was on Biktarvy, she would not have admitted the resident because it costs thousands of dollars and Medicaid does not cover the cost. The resident came with nothing, and they could not put his/her orders into the electronic medical record until the resident's paper chart was found and delivered to them. The resident could not tell you about his/her care or medications. The resident's parent visited (date unknown) and told them about the resident's brain infection, which was why the resident was not him/herself anymore. The resident initially admitted to the previous Missouri facility sister facility on [DATE], and the pharmacy sent them a 30-day supply of the Biktarvy on [DATE]. The pharmacy said it was too early to be delivered here, before [DATE]. Additionally, the Biktarvy, which cost $4,000.00 per month, exceeded the facility's maximum designated dollar amount, so the pharmacy would not send it. They also would not send it because their sister Missouri nursing home, which closed on [DATE], had not paid for the Biktarvy sent to them on [DATE]. There was no substitute for Biktarvy, so a replacement could not be ordered. Additionally, they did not know which ID Clinic or ID Physician, was following the resident, because they did not get the resident's paper chart until [DATE].<br><br>During an interview on [DATE] at 10:38 A.M., the DON said she recalled being told something about the pharmacy not sending the Biktarvy, because their sister facility had not paid them the $4,000 owed for the Biktarvy delivered on [DATE]. However, she never spoke with the pharmacy about the resident's Biktarvy and never received a fax from the pharmacy, regarding the resident's Biktarvy. The facility has 4 or 5 faxes and there is no telling where the fax went.<br><br>During an interview on [DATE] at 3:13 P.M., the Administrator said she did not recall when she became aware the resident was not receiving his/her Biktarvy. She did not recall seeing a fax from the pharmacy, regarding the resident's Biktarvy needing Administrator approval because the cost was over their limit, and the pharmacy did not call her for approval. She recalls calling the pharmacy once, but they were out and did not get back with her.<br><br>Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the on-site visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.<br><br>At the time of the exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).<br><br>MO00230073 |